Healthcare services, the EU single market and beyond

Healthcare services, the EU single market and beyond: meeting local needs in an open economy—how much market or how little market?

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Abstract

This paper considers the impact of the choices made by the member states in designing the institutional and regulatory concerning taxpayer-funded health services on the applicability of the EU single market and competition rules and on the public procurement legal regime. It will focus on the different approaches adopted in the United Kingdom in England and Wales as opposed to Scotland. The paper will conclude by looking at some of the issues that could arise from the implementation of common commercial policy initiatives undertaken by the Union: taking in consideration the ongoing negotiation of the EU/US Transatlantic Trade and Investment Partnership (TTIP), it will consider whether liberalising trade in services may imperil the solidarity-based nature of healthcare that is typical of the EU member states.

1. Introduction

The question of how publicly funded healthcare services should be provided has been one of the crunch points in the legal, political and economic debate since the inception of the modern welfare states. Should these economic activities be the exclusive purvey of public agencies, so as to reach all affected individuals free at the point of need? Or can an element of "private enterprise participation" be allowed? The realisation of the internal market within the European Union, with its emphasis on market access and competition, has added a further dimension to these debates: although the Treaty on the Functioning of the European Union (TFEU) allows to the member states a significant margin of discretion in choosing how to design the frameworks for publicly funded healthcare provision, it regards these services as falling within the scope of the single market principles. Against this background, the limited "supporting and coordinating" competence that the Union enjoys in this area must be seen as the tool through which the EU institutions can prevent the exercise of state powers from unduly encroaching upon the good functioning of the internal market.

Accordingly, a complex picture emerges when it comes to examining the position of these public services in the context of the EU treaties: on the one hand, there is a concern for allowing the member states, as best placed to assess the healthcare needs of their populations, to determine how these services should be provided to individual users, according to local demands for patients' care and public health. On the other hand, the single market principles enshrined in the TFEU place limits on this discretion to ensure the respect of free movement of persons and services' rules, albeit within the framework of public policy interests that characterise, inter alia, public health provision.

The goal of this paper is to consider some of the questions arising from the impact of the choices made by the member states in designing the institutional frameworks for and in regulating

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the provision of taxpayer-funded health services on the applicability of these single market principles, of the competition rules and on the public procurement legal regime. In this context, the different approaches adopted in the United Kingdom for the functioning of the National Health Service (NHS) in England and Wales as opposed to Scotland will be examined. Toward the end, the paper will also briefly address some of the issues that could arise from the implementation of common commercial policy initiatives undertaken by the Union as an international actor: taking in consideration the ongoing negotiation of the EU/US Transatlantic Trade and Investment Partnership (TTIP), it will be examined whether liberalising trade in services with undertakings affiliated to a non-member country may actually imperil the solidarity-based nature of healthcare that is typical of the EU member states.

It will be argued that maintaining an effective provision of healthcare services funded by general taxation and free at the point of need remains a central aspect to the mission of European welfare states, so as to achieve, as also mandated by the TFEU, high levels of public health: for this purpose, it will be shown that the Treaty itself both safeguards, in accordance with the principle of subsidiarity, the power of appreciation of individual member states as they seek to fulfil the demands of their own population and at the same time contain the scope of this discretion to ensure that domestic measures do not hamper the good functioning of the internal market. It will be illustrated that the TFEU allows for derogations from the reach of the free movement principles for reasons of public policy, albeit in the respect of requirements of proportionality and necessity, as well as allowing the provision of services according to mutuality principles to "escape" from the scope of application of the competition rules. It will also be shown that the respect for the same principle of subsidiarity has justified the emergence of a "light touch regime" for public contracts concerning "essential services to the person".

It will be concluded that while the concerns for the future of the provision of taxpayer funded healthcare services "free at the point of need" are certainly justified, also in light of broader societal issues, such as the growth of an ageing population and the correspondingly limited financial resources, the reach of the EU single market rules or indeed the current developments in the field of common commercial policy should not be regarded as a threat to the discretionary powers that the member states enjoy in this area. It will be argued that whether to "open up" publicly funded healthcare provision to the market or, on the contrary, to maintain it "within public hands" is a choice that remains with the member states: thus, save for a Treaty amendment for that specific purpose, the EU, on its part, cannot in any way force the "privatisation" of these services, whether through internal measures or action on the international plain.

2. Public health care and the Single Market: between encouraging free movement and ensuring the survival of domestic populations…

2.1. Healthcare provision and the single market: a "special type" of services?

Health care services funded by the taxpayer and provided "free at the point of need" to individual patients are a mainstay of the EU member states, being regarded as "the quintessential public service" which should be guided by "principles of equal access and equal treatment of patients".[1] On this point, it should be noted that the TFEU lists the objective of attaining a high level of protection of human health across the Union as one of the Union's objectives.[2] The CJEU has indicated that while in principle they remain subject to the free movement rules,[3] these services were of a "sensitive nature" [4] and that consequently, absent any harmonisation in this field, member

[1] Prosser, The Limits of Competition Law, 2005: Oxford, OUP, p. 7; see also p. 9.

[2] See e.g. Declaration of the Contracting Parties on Article 168(4) TFEU, attached to the TFEU and agreed at the Lisbon Inter-Governmental Conference.

[3] See e.g. Opinion 1/2008, Re: GATS, [2009] ECR I-11129, para. 130, 132-134.

[4] See e.g., mutatis mutandis, case 159/90, SPUC v Grogan, [1991] ECR I-4685, para. 18.

states should be recognised the power to assess the demands of public health within their jurisdictions and on that basis determine the entitlement to healthcare benefits for individuals as well as the way in which these services should be provided and financed.[5]

Thus, in *Kohll* the CJEU accepted that, in principle, a concern for "seriously undermining the financial balance of a social security system"[6] and in particular for "maintaining a balanced medical and hospital service open to all"[7] could provide a justification for limiting the reach of that freedom. However, it took the view that any limitations and conditions could only be justified in light of the requirements of the Treaty if they were "(…) necessary to provide a balanced medical and hospital service accessible to all (…)": the Member States could establish rules designed to govern the reimbursement of medical expenses for services obtained by the patient in a different member state with a view to securing "(...) treatment capacity or medical competence on national territory" and, as a result, to protecting the health and survival of their populations.[8] Nonetheless, the CJEU took the view that since these rules could discourage individuals from seeking medical care elsewhere in the internal market,[9] they could only be justified if they were appropriate to attaining goals of public policy such as, inter alia, guaranteeing "sufficient and permanent access to a range of high quality treatment" and to "prevent (…) any wastage of financial, technical and human resources".[10] They should also have been "(…) based on objective, non-discriminatory criteria which are known in advance" and applied in a non-arbitrary manner.[11]

It is further noted that the scope of that discretion and the choices made by the competent national authorities in the area of public healthcare provision have a significant impact on the scope of application of the EU competition rules. While the remit of this contribution does not allow for any in-depth consideration of general issues arising from the design of healthcare systems, it is necessary to note that one of the key principles according to which these services are provided is the principle of mutuality: thus, the EU Court of Justice held in the *Poucet* preliminary ruling[12] that providing social security or sickness benefits would not represent an "economic activity" for the purpose of applying, inter alia, Article 102 TFEU if this occurred on the basis of purely solidarity based criteria.[13] In the EU Court's view, providing that, the benefits should have been accessible to all, membership to the scheme should have been compulsory and the amount available be the same for all subscribers,[14] the bodies responsible for the management of these schemes would not constitute 'undertakings' on the ground that, to the extent that they were operating without a profit motive and in accordance with the principle of solidarity, they fulfilled a purely social function.[15]

A similar approach was adopted by the CJEU for the provision of taxpayer-funded healthcare services: in *FENIN*[16] the General Court took the view that national health authorities who, for instance, purchased large supplies of medical equipment to be used to provide "universal" healthcare benefits to individuals, financed via social security contributions and supplied free-of-charge, could not be regarded as "undertakings" for competition law purposes,[17] on the ground that

[5] Cases 286/82 and 26/83, Luisi and Carbone v Ministero del Tesoro, [1984] ECR 377, para. 16. See also case C-156/98, Kohll, [1998] ECR I-1931, para. 20.
[6] Id., para. 41.
[7] Id., para. 50.
[8] Id., para. 73-74.
[9] Id., para. 75.
[10] Id., para. 77-79.
[11] Id., para. 90; see also para. 87-89.
[12] Case C-159/91, Poucet v Assurances Générales de France and Caisse Mutuelle Régionale du Languedoc-Roussillon, [1993] ECR I-637.
[13] Id., para. 10; see also para. 8.
[14] Id., para. 13.
[15] Id., para. 17-19.
[16] Case T-319/99, FENIN v Commission, [2003], ECR II-357, para. 35, 38; see also, inter alia joined cases C-264/01 and others, AOK Bundesverband and others, [2004] ECR I-2493, para. 46.
[17] Id., para. 36-37; see also para. 39-40.

their supply-side activity could not be separated from the fulfilment of their statutory mandate for which these purchases were conducted.[18] Thus, since the provision of services to citizens was based on principles of universality and of solidarity, the institution or body concerned could not be subject to the Treaty competition rules.[19]

It may be concluded that, in principle, healthcare services, even when they are publicly funded, remain subject to the EU single market and competition principles. However, member states retain extensive powers when designing and regulating the frameworks for their provision, albeit within constraints of "necessity", "proportionality" and non-discrimination. Also, as was illustrated in respect of the *FENIN* judgment, the choices as to the design of these systems can have a significant impact on the extent to which free market principles such as the competition rules can apply to the providers of these services, thus allowing for "non-economic considerations" to continue to apply in this area. The next section will consider the nature of the competence enjoyed by the Union in the field of healthcare services and how this interacts with the "sovereignty" that member states retain vis-à-vis their healthcare services.

2.2. Healthcare services and the TFEU—pursuing the public interest between limited competences and the good functioning of the single market

The previous section considered the question of the "nature" of state-funded health services in the context of the TFEU and the issue of the extent to which they would be subject to the rules on free market and competition. This section will consider the implications of the approach emerging from the case law for the EU's own powers and in particular examine whether the Union can adopt measures affecting the provision of healthcare services, including those that are publicly funded.[20] According to Article 6 of the TFEU, public health is an area in which the Union enjoys competence only limited to "support, coordinate and supplement" the action of the Member States.

Article 168(7) TFEU further states that the Union can only take action to encourage mutual coordination and in that context improving the "complementarity of their health services in cross border areas (…)", for the purpose of ensuring a high level of human health protection.[21] Thus, the member states can decide independently how to organise, design and finance healthcare provision within the respective jurisdictions.[22] The EU institutions, on their part, can only enact measures to encourage state coordination in, inter alia, the provision of health care services in cross-border situations so as to ensure that the sovereign powers enjoyed by the member states in this area do not unduly encroach upon the free movement of persons and of services' rules.[23]

It is suggested that a good example of how this power is to be exercised is provided by the "Patients' Directive", i.e. Directive 2011/24/EU.[24] The Directive crystallises[25] a number of rights that the CJEU had already been recognised for EU citizens enjoying their free movement rights vis-à-vis health authorities, including, for instance, the entitlement to the reimbursement of expenses incurred in seeking cross-border health services that are among the benefits to which they would

[18] Id., para. 36.
[19] Id., para. 39; see also case C-205/03 P, Fenin v Commission, [2006] ECR I-6295, para. 25-27.
[20] For an analysis of the powers enjoyed by the EU in the area of public health see e.g. Toebes at al., "The European Union and health and human rights", (2011) 4 EHRLR 411; Hervey and Varhencke, "EU law and public health: the law and policy patchwork", in Hervey et al. (Eds), Health systems Governance in Europe, 2010: CUP, p. 84-113.
[21] See e.g. , mutatis mutandis, case C158/96, Kohll, [1998] ECR I-1931, para. 18.
[22] See e.g. case C372/04, Watts, [2006] ECR I-4325, para. 86 and 92; see also case C-385/99, Muller-Faure', [2003] ECR I-270, para. 102-103.
[23] See e.g. C-157/99, Geraets-Smits et al., [2001] ECR I-5473, para. 44-45.
[24] Directive of the European Parliament and the Council of 9 March 2011No 24 on the application of patients' rights in cross-border healthcare, [2011] OJ L88/45, Preamble, Recital 10.
[25] Id., recital 11.

have been entitled in their state of origin.[26] However, it only goes as far as to ensure that the functioning of the single market is not unduly impaired in the face of the significant autonomy enjoyed by the member states,[27] with national governments and parliaments remaining fully responsible for deciding how to provide these services, in accordance with the principle of subsidiarity[28] and with the requirements laid down in, inter alia, Article 56 TFEU.[29]

Thus, in the landmark *Watts* decision the Court of Justice took the view that EU law did not prejudice the power of the member states to determine the conditions according to which social security benefits (including taxpayer-funded medical care) should be provided.[30] In this context, it was recognised that reducing the "risk of seriously undermining the financial balance" of the framework for the provision of these services would represent an "overriding reason in the public interest" for limiting their freedom of movement.[31] Subject to an assessment of whether any restrictions aimed prima facie at protecting the financial soundness of medical services provision were both appropriate and objectively necessary to attain this objective, ultimately in the interest of the survival of the population as a whole,[32] the member states could, inter alia, limit the entitlement of nationals of other member states to receive medical care within their jurisdiction.[33]

It is submitted that broadly similar principles seem to underscore the approach adopted by the EU in the field of public procurement of these services. While the remit of the paper does not allow for an examination of the discipline of public contracts in the Union and in the Member States, it is indispensable to note that private enterprises have come to play an increasingly important role in the delivery of public services: the stipulation of these contracts is subject to rules (both substantial and procedural) that are largely harmonised[34] and that aim to pursue a commitment to transparency and non-discrimination (especially on grounds of nationality) vis-à-vis all potential bidders, to ensure the good functioning of the single market.[35] Nonetheless, it is legitimate to query whether considerations that are not strictly speaking of an "economic nature" can affect the applicability of these rules. It is suggested that these considerations are relevant both when it comes to deciding how to award a specific contract—e.g. whether it is necessary to "go out to tender" or whether, for example, it may be more appropriate to provide a specific service "in house"—and when establishing the selection criteria for winning bids: for this purpose, can the awarding body identify successful participants on the basis of, e.g. geographical criteria associated with the localisation of service providers to ensure continuity and quality of care for patients?[36]

As a preliminary point, it must be noted that the current Directive concerning the award of public contracts, consistently with the principles underpinning Article 168 TFEU, recognises the "sovereignty" of member states on the way in which the provision of these and, in general, of the

[26] See Article 7 of Directive 2011/24.
[27] See e.g. Sauter, "The impact of EU Competition law on national healthcare services", (2013) 28(4) ELRev 457 at 463-465.
[28] Ibid.; see also, mutatis mutandis, Opinion 1/08, cit. (fn. 3), para. 133, 136; also case C-385/99, Muller-Faure', [2003] ECR I-270, para. 102-103; Fenin, cit. (fn. 16), para. 38-40.
[29] See inter alia, mutatis mutandis, Opinion 1/08, loc. ult. cit.; also case C-385/99, Muller-Faure', [2003] ECR I-270, para. 102-103; case T-319/99, FENIN v Commission, [2003], ECR II-357, para. 35, 38-40. For commentary see inter alia Odudu, "Are state owned healthcare providers that are funded by general taxation undertakings subject to competition law?", (2011) 32(5) ECLR 231.
[30] Case C372/04, Watts, [2006] ECR I-4325, para. 92.
[31] Id., para. 102-103.
[32] Id., para. 104-106.
[33] Id., para. 110-111.
[34] See chiefly Directive of the European Parliament and the Council 2004/18/EC, [2004] OJ L134/114.
[35] Id., see e.g. Preamble, Recitals 1-3.
[36] See Directive of the European Parliament and the Council No 2014/24/EU, [2014] OJ L94/65, Preamble, Recital 118.

"essential services to the person" should be organised,[37] including determining how these providers should be chosen.[38] National agencies responsible for the provision of publicly funded health care services can therefore opt for doing so "in-house", either directly or via entities that they themselves control; [39] they can also decide to grant licenses to outside bodies that meet objective selection criteria identified in advance.[40] Alternatively, health authorities can decide to "contract out" specific services and select the firm or firms to which the relevant contracts should be awarded on the basis of criteria that are not solely based on the "value-for-money" principle but also on more quality-based requirements[41] linked to inter alia, the need to ensure the "continuity in the provision of public services" or the nature--whether mutualistic or otherwise--of organisations seeking to bid for relevant contracts.[42]

Thus, in *Commission v Ireland* it was held that public authorities would not be obliged to "go out to tender"[43] if they were seeking to source services that they were under a statutory obligation to provide—such as emergency ambulance cover designed to assist fire services.[44] In these cases, no "public contract" could be said to exist on the ground that the services concerned by it would be supplied "to the public, in the exercise of [the authority's] own powers derived directly from statute".[45] As a result, none of the public procurement principles would apply.[46]

In *Teckal* the Court of Justice added that a Member State could opt for the "in-house" supply of public services, either directly or via controlled entities.[47] However, even if a "public contract" was to be concluded and consequently—if all the other relevant conditions were met—the awarding body was under an obligation to "go out to tender", it could rely on a "light touch regime" that the EU public procurement legislation recognises as being applicable to contract for the provision of "essential services to the person".[48] Accordingly, public agencies could identify and apply non-economic criteria to the selection of winning bids, such as requirements inspired by the need to maintain continuity of care through geographic proximity of providers to patients, by concerns for securing the involvement of service users in that provision and, more generally, with a view to maintaining consistent and high quality of medical services.[49] In any event, the award of these contracts remained subject to minimum requirements of transparency and of non-discrimination.[50]

It may be concluded that Article 168 TFEU affords member states a significant degree of discretion in determining their approaches to publicly funded healthcare provision, although the domestic authorities must abide by basic Treaty principles concerning the good functioning of the single market. Whether healthcare services are provided directly or "contracted out" to private

[37] See inter alia, mutatis mutandis, case C-300/07, H &C Oymanns GbR and others, [2009] ECR I-4779, para.51-56; see also para. 59.

[38] See Directive of the European Parliament and the Council No 2014/24/EU, [2014] OJ L94/65, Preamble, Recital 114; for commentary, see e.g. Hatzopoulos, "Public procurement and state aid in national health care systems", in Hervey et al. (Eds), Health Systems Governance in Europe, 2010: CUP, pp. 389 ff.

[39] See e.g. case C-324/98, Telaustria, [2000] ECR I10745, para. 60-61.

[40] Ibid. See also Directive 2004/18/EC, OJ 2004 L134/114, Annex II B.

[41] Ibid.; inter alia, see case C-321/03, Coname, ECR I-7287, para. 16-19.

[42]Directive 2014/24, cit. (fn. 38), Recital 118, Preamble.

[43] Case C-532/03, Commission v Ireland, [2007] ECR I-801, para. 26-28; see also para. 35-36.

[44] Id., para. 31-32.

[45] Id., para. 33-35.

[46] Id., para. 35-36.

[47] Case C-107/98, Teckal Srl, [1999] ECR I-8121, para. 49-51.

[48] See e.g. most recently, case C-568/13, Azienda Ospedaliero-Universitaria di Careggi-Firenze v Data Medical Service Srl, judgment of 18 December 2014, nyr, para. 32-36; see also, inter alia, case C-305/08, COniSMA, [2009] ECR I-12129, para. 37, 43.

[49] See e.g., mutatis mutandis, case C-160/08, Commission v Germany, judgment of 29 April 2010, para. 124 ff. For comment see e.g. Wiggens, "Public procurement rules and cooperation between public sector entities", (2011) 5 PPLR 157, especially pp. 158-159.

[50] See e.g. Teckal, cit. (fn. 47), para. 26.

providers, if necessary via public procurement processes, the competent agencies retain significant powers of appreciation in determining the rules according to which services should be supplied, the eligibility of users, the way in which they should be financed and, especially when public contracts are concluded, how winning bidders should be selected.

3. Health care between the internal market and national sovereignty: how does it work in practice? The case of the United Kingdom

3.1. The NHS as a tale of two nations: introductory remarks

The previous sections discussed the position of publicly funded healthcare services in the context of the EU single market: it was illustrated that while in principle they remain subject to the Union rules on free movement and competition, the member states retain a significant degree of discretion when it comes to meeting the needs of public health of their population and especially to regulating access to and financing of these services, with the EU, as a consequence, enjoying only limited competences.

The limited scope of this paper does not allow for a detailed consideration of the complex questions concerning the design of health care systems in individual jurisdictions.[51] Suffice it to say at this junction that in all the EU member states the provision of what has, as anticipated, been regarded as a key public service has traditionally occurred in light of principles of solidarity, equity, efficiency and affordable cost.[52] However, as was illustrated in the earlier sections, the "sovereignty" enjoyed, albeit within limits, by each member states as regards the design and regulation pf publicly funded health care service provision has meant the emergence of different models and approaches, whether structural or concerning the regulation of these services.

Two different models can be identified as providing the most common blueprints in this context. On the one hand, the "Beveridge" model entails that the universal provision of healthcare services free at the point of need be financed via general taxation; on the other hand, the "Bismarck" model relies on the role of sickness insurance schemes and institutions, to which all citizens are members and whose task is to invest contributions and use the revenue from these investments to fund sickness costs.[53] A quick glance at the various systems across the Union reveals that there is significant variance in how these models have been implemented in each jurisdiction: challenges arising from an ageing and expanding population, whose needs are more and more diverse, and from increasingly limited financial and human resources have prompted all EU governments to consider how the supply mechanisms of these services can be rationalised so that current needs can still be met within the limits of a less generous settlement.[54]

To address these challenges, some member states have stuck to the "traditional" state-owned and controlled provision of these services, in accordance with the tenets of the "Beveridge" model and with the European idea of the welfare state.[55] Others, instead, have opted from moving away, at least in part, from state-funded and, to an extent, solidarity-run structures toward the design of frameworks in which private providers on the one hand are more active and on the other hand healthcare agencies have become more independent of central government, on occasion to the

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[51] See e.g. European Parliament, "Health care systems in the EU: a comparative study", (1999) SACO 101 EN (hereinafter referred to as 'European Parliament report'), available at: http://www.europarl.europa.eu/workingpapers/saco/pdf/101_en.pdf; see also the Health Systems and Policy Monitor (HSPM) website, run by the European Observatory on health policies and systems, available at: http://www.hspm.org/mainpage.aspx (hereinafter referred to as 'HSPM'), both last accessed on 17 January 2016.

[52] See European Parliament Report, p. 5.

[53] Id., pp. 5-6; see also pp. 18-21.

[54] Id., p. 21.

[55] Ibid.; see also p. 19.

point of being competent to negotiate and oversee the implementation of services' contracts with outside providers, whether public or private.[56] In this specific context, the creation of a "split" between purchasers and providers of services has been regarded as essential for enhancing patient choice, creating greater efficiency in the delivery of services and improving cost effectiveness: at the core of these reforms, which have been taking place in several member states especially since the late 1980s and early 1990s has been the concern for creating an "internal market" in health care services, where competition would act as a central factor to achieve these objectives.[57]

Against this background, important questions emerge as to how the "sovereignty" enjoyed by the member states in respect of these matters can affect the scope and manner of application of the internal market rules. To address these issues, the way in which the United Kingdom's National Health Service (NHS) is organised in England and Wales as opposed to Scotland will be analysed. As will be illustrated in greater detail in the following sections, the Scottish Parliament, to which competence in the field of public healthcare has been devolved as a result of the Scotland Act 1997,[58] has opted to retain the NHS fully in public hands, i.e. within the ownership and under the control of the Ministry of Health.[59] By contrast, the Government and Parliament in London have progressively endeavoured to extend market based principles to this sector.[60] This process was catalysed by the enactment of the Health and Social Care Act 2012.[61]

Due to the high level of trust that the NHS enjoys,[62] it was inevitable that the "push" toward its marketization in England and Wales would fuel the concern that eventually the total privatisation of healthcare may occur.[63] In parallel, a number of stakeholders has raised questions for the continuing sustainability of the fully public frameworks existing in Scotland, especially in respect of public procurement. The next sections will consider whether these concerns are justified, having regard to the NHS's set up existing, respectively, in Scotland and in England and Wales.

3.2. The NHS in Scotland: relying on cooperation and state control, and ownership as a means of seeking optimal provision of publicly funded medical care

The purpose of this section will be to provide a short overview of the NHS in Scotland and thereafter to attempt to gauge, however briefly, the extent to which the framework for healthcare provision is affected by the single market rules, namely free movement and competition principles. As was anticipated, the power to legislate in relation to the structure and functioning of the NHS in Scotland, as a "devolved matter" under the Scotland Act 1997, has been exercised so as to keep the NHS "in public hands".[64] Its running is entrusted to fourteen area boards, responsible for the

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[56] Id., p. 22.

[57] Ibid.; for commentary, see inter alia Guillen and Pavolini (Eds), *Health care systems in Europe under austerity: institutional reforms and performance*, 2013: Basingstoke, Palgrave, see especially pp. 193 ff. (Chapter 9).

[58] See e.g. SPICe Briefing, "The National Health Service in Scotland", 21 June 2011, No 11/49, pp. 5-6. For commentary see inter alia Curran and Albert, "It seemed a good idea at the time", (2014) 35(9) ECLR 419; see also Pownall, "Neoliberalism, austerity and the Health and Social Care Act 2012", (2013) 42(4) Industrial L J 422 at 429-430.

[59] See e.g. SPICe Briefing, "The National Health Service in Scotland", 21 June 2011, No 11/49, pp. 5-6.

[60] See e.g. Pownall, cit. (fn. 58), p. 430.

[61] Ibid.

[62] See e.g. the summary data available at: http://www.nhsconfed.org/resources/key-statistics-on-the-nhs. See also, for comparison: House of Commons, Note: NHS funding and expenditure, SN/SG/724, 3 April 2012, available at: http://www.nhshistory.net/parlymoney.pdf, sect. 1.1-1.2.

[63] See e.g.: http://www.patients4nhs.org.uk/eu-us-free-trade-agreement-or-ttip/; see also the Resolution adopted by the English TUC at the 2014 Annual Conference on TTIP, available at: https://www.tuc.org.uk/international-issues/trade/congress-2014-composite-resolution-transatlantic-trade-and-investment.

[64] See e.g. SPICe Briefing, "The National Health Service in Scotland", cit. (fn. 59), pp. 5-6.

allocation of resources and the implementation of healthcare strategies via NHS Boards, Community Health Partnerships and Operating Divisions.[65] These bodies operate according to principles of cooperation and are under direct control of the competent Minister.[66] Performance objectives are set by the Scottish Government and achieved by NHS Boards, in accordance with the relevant delivery plans, under ministerial supervision.[67]

At the core of their strategy is a commitment to providing "(…) safe, high quality services that are as local as possible and as specialised as necessary",[68] so as to maintain high levels of public health, safeguarding the survival of their population and protecting the financial stability of their own health frameworks.[69] This objective is met in a variety of ways, ranging from the provision of services "in –house"—either directly or via bodies under the control of the NHS Scotland's Boards—or through the commissioning of these services in accordance with framework agreements that are negotiated on a UK wide basis.[70]

Under the leadership of the Government's General Directorate for Health, the Boards, acting as "all-purpose organisations" and closely supervised by the local area partnerships,[71] provide services to patients either directly or by commissioning them to independent contractors, such as, among others, GPs, dentists and pharmacies.[72] They are responsible for the provision of hospital care, on a territorial basis, as well as for ensuring key services in cooperation with local authorities and communities via local area partnerships. Overall quality of service and continuity of provision are guaranteed via specialised agencies, such as Healthcare Improvement Scotland.[73] Central to the activity of the Scottish NHS is a strong emphasis on collaboration, partnership and the sharing of resources across the sector; in addition, the fact that there is no "split" between purchaser and provider means that there is no such a thing as a "contract" for the supply of key services, such as, inter alia, hospital care, which is managed "in-house" by a bespoke operating division of each Board.[74]

It is suggested that a parallel can be drawn between the structure of the Scottish NHS and the framework for the provision of public healthcare existing in, inter alia, Denmark, where medical services are delivered by a wholly publicly funded and owned system articulated in central, regional and local agencies who act under the overarching supervision of the Ministry of Health.[75] Just as in Scotland, Danish patients access out- and inpatient services by consulting their general practitioners first—who therefore act as "gatekeepers": hospitals are owned, by and large, by regional or local health agencies and services are supplied directly by the public healthcare organisation, without there being any "split" between purchasers and providers.[76] Publicly funded health care is predominantly funded by general taxation, with co-payment by patients being required for certain services (such as dental care).[77]

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[65] Ibid.
[66] See e.g. http://www.scotland.gov.uk/Topics/Health/About/NHS-Scotland.
[67] See inter alia http://www.ournhsscotland.com/our-nhs/nhsscotland-how-it-works.
[68] See Kerr Report: Delivering for health, 2 November 2005, available at: http://www.scotland.gov.uk/Publications/2005/11/02102635/26356, Executive summary.
[69] See e.g. Watts, cit. (fn. 22), para. 86 and 92; see also Muller-Faure', cit. (fn. 22), para. 102-103.
[70] See inter alia SPICe briefing, cit. (fn. 59), pp. 4 ff.
[71] Id., see e.g. pp. 5-6 and 17-18.
[72] Ibid.
[73] Ibid.
[74] See inter alia Timmins, "The four UK health systems", paper produced for the King's Fund, in association with European Observatory, available at: http://www.kingsfund.org.uk/publications/four-uk-health-systems-june-2013, p. 4-5.
[75] See European Parliament Report, p. 41-41; see also Denmark, Country report, submitted to the HSPM, available at: http://www.hspm.org/countries/denmark27012013/countrypage.aspx; see especially section 2.1.
[76] Ibid., see section 5.1. and 5.3.
[77] Ibid.,section 3.2; see also sect. 3.3-3.4; see also European Parliament Report, p. 44.

In light of the forgoing analysis, it is submitted that to the extent that these powers have been devolved to the Scottish Government and the Scottish Parliament as a result of the constitutional settlement reached in the UK in 1997, the regional authorities in Edinburgh have opted for "shaping" the Scottish NHS according to principles of public stewardship, cooperation and governmental control and thereby limiting the reach of the tenets of the free market and of private sector involvement in the provision of these services free at the point of need.[78] Adopting this institutional choice, however, has significant consequences for the applicability of the EU internal market and competition rules.[79] It is argued that to the extent that taxpayer-funded medical services are provided "in-house", the relevant commercial practices are likely to be regarded as the expression of "single firm conduct" and as such falling outside the remit of Article 101 TFEU.[80] It is added that the circumstance that these services are provided free at the point of need and thus pursue a mutuality-based goal is strongly indicative of their "non-economic nature":[81] thus, in accordance with the principles enshrined in the *FENIN* judgment, it is suggested that this may exclude the applicability of the EU competition rules and in particular, in as much as health authorities are likely to wield significant market powers in respect of their purchasing and supplying patterns, Article 102 TFEU.[82]

It is further observed that the choices of health care systems' design made in Edinburgh have equally important consequences for the extent to which the obligations arising from EU public procurement legislation are applicable to potentially "awarding bodies" within Scotland. As was illustrated above, it is expected that since the bulk of these services are provided in-house, public procurement legislation is going to receive very limited application.[83] If however Scottish health agencies were to source services from the private sector and for that purpose either opted for or were obliged to go out to tender, they would remain entitled to rely on the "light touch regime" that the EU legislation provides for "essential services to the person": thus, beyond general obligations of transparency and non-discrimination, they can identify selection criteria for winning bids that are "non-economic" in nature or indeed not linked to the "value for money" concept.[84]

It is therefore concluded that the nature of the choices made by the Scottish authorities in respect of its structure and operation, any degree of "opening up to the market" for the devolved NHS is unlikely to derive from the application of the Union single market principles. It should also be emphasised that important safeguards, such as the principles of conferral and of subsidiarity, contribute to protecting the scope of discretion that the Parliament in Edinburgh enjoys in this area.

3.3. State-funded healthcare in England and Wales—toward a "neoliberal" framework for the provision of these services… but what does this mean for market access?

The previous section briefly outlined the key principles governing the design and the functioning of the NHS in Scotland and in that context discussed the impact of the choices made in this area on the achievement of the internal market. The situation is, however, admittedly very different in England and Wales, where, unlike in Scotland, there has been a clear "push" toward creating a "internal market" of health care services, especially since 2010. The Health and Social Care Act 2012 was enacted for the purpose of "(…) promot[ing] competition amongst an increasingly diverse base of private, public and non-profit providers of public services, with the ultimate aim of raising the standards of service-provision and reducing its costs (…)".[85] To achieve these objectives, the Act abolished bodies such as the Primary Care Trusts and the strategic health authorities, along with the

[78] Timmins, cit. (fn. 74), see especially pp. 18-19.
[79] See e.g. Geraets-Smits et al, cit. (fn. 23), para. 44-45.
[80] See e.g., mutatis mutandis, case C-73/95, Viho Europe v Commission, [1996] ECR I-465.
[81] See, Geraets-Smits, loc.ult.cit.
[82] FENIN, cit. (fn. 16), para. 35-40.
[83] See inter alia, case C-305/08, COniSMA, [2009] ECR I-12129, para. 37, 43.
[84] Ibid.
[85] Sanchez-Graells, "New rules for healthcare procurement in the UK", (2015) 1 PPLR 16 at 19.

NHS executive, and replaced the former with Clinical Commissioning Groups (CCGs) and with a new NHS England commissioning board: CCGs act under the supervision of the commissioning board, which is also responsible for the direct purchasing of certain specialised services.[86] They are led by GPs and are responsible for the purchasing of medical services from third party providers, which in turn can either be publicly (e.g. NHS Foundation Trusts) or privately owned.[87]

As a result of the 2012 Act the framework for the provision of healthcare services has reverted to reliance on the "purchaser-provider" split that had characterised their provision for much of the 1980s and until 1997.[88] On this point, a parallel can be drawn with the structure of the Health Services existing in Spain and in Sweden. In respect to the former, a recent report of the European Observatory of Health Policies and Systems (HSPM) found that health authorities are competent for setting out budgets, identifying healthcare objectives and monitoring their achievement. For this purpose, they act as purchasing agencies vis-a-vis service providers, which are selected according to a number of principles, such as, among others, value for money and the need to secure the most efficient use of resources.[89]

It should be noted that at the core of these reforms was at least initially a concern for enhancing efficiency and stability of the Spanish Health Service (Servicio Nacional de la Salud, SNS) both at central and at regional and local levels. This end was to be attained via the introduction of "elements of market simulation" to achieve greater cost effectiveness and guarantee patient choice. However, as was illustrated more recently by the HSPM, the outcome of these reforms in practice has been markedly different: the updated Country Report found that these changes have encouraged the modernisation of management practices within the SNS and ushered the emergence of an evaluation-based culture, with clear gains, such as, inter alia, the more efficient allocation of limited resources and more transparent and effective management.[90] In this context, significant emphasis was placed on the connection between budgetary constraints and the scope and nature of the activity undertaken by health bodies and on the importance of constant monitoring on the use of resources and on accountability of providers.[91]

Partly similar considerations can be made in respect of Sweden. Commentators observed that the purchaser-provider split introduced in that jurisdiction was based on "contract management and evaluation" and relied on a robust competitive process for the selection of providers.[92] Accordingly, it was argued that the move toward a separation between purchasing and provision functions should have been seen as a tool for enhancing competition and transparency during the phase of tendering and selection of providers, so that the "best bid" can be identified.[93] Seen in this light, it was suggested, therefore, that the purchaser-provider split had been introduced not so much to create competition "in the market" for the supply of medical services funded by the taxpayer, but as a means of enhancing competition "for the market" by exposing the process of selection of winning bidders to genuine transparency and rivalry.[94]

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[86] See Timmins, cit. (fn. 74), p. 13.
[87] Id., pp. 3-4.
[88] Id., p. 3-4.
[89] See country report: Spain, published by HSPM and available at: http://www.hspm.org/countries/spain25062012/livinghit.aspx?Section=4.1%20Regulation&Type=Section, last accessed on 28 January 2016.
[90] Ibid.
[91] Ibid.; see also, e.g., section 6.1 of the report, available at: http://www.hspm.org/countries/spain25062012/livinghit.aspx?Section=4.1%20Regulation&Type=Section, last accessed on 28 January 2016.
[92] Siverbo, "The purchaser-provider split in principle and practice: experience in Sweden", (2004) 20(4) Financial Accountability and Management 401, pp. 409-410.
[93] Id., pp. 410-411.
[94] Ibid.; see also HSPM, Country report: Sweden, available at: http://www.hspm.org/countries/sweden25022013/livinghit.aspx?Section=5.1 Public health&Type=Section, last accessed on 28 January 2016, especially section 2.8.

The summary analysis conducted above seems to show that just as in England and Wales, other member states have faced the question of how to achieve efficiency, affordability and greater patient choice and have chosen to tackle it via the adoption of "market-inspired" solutions in the sourcing and supplying of services. However, it appears to emerge from the cursory examination of the impact of the purchaser-provider split in other member states that these reforms have had a considerably different impact in these jurisdictions as opposed to England and Wales. It is suggested that in Spain and Sweden there seems to be a greater concern for ensuring open, transparent and cost-efficient tendering so that the "best provider" can be allowed to emerge and can be held accountable once it performs its functions.[95] In England and Wales, instead, the Health and Social Care Act has been implemented with a view to adhering more closely (albeit not fully, as will be seen below) to free market principles and to upholding competition not just "for the market" but "in the market".[96] It is emphasised that the 2012 Act imposes on NHS commissioners an obligation not to engage in anti-competitive behaviour unless restrictive practices are justified "in the patients' interest".[97] To ensure the effective application of this principle, the Act has conferred on the sector regulator, Monitor, which is generally responsible for authorising new entities seeking to start providing healthcare services and for regulating their activity competition enforcement powers, the requirement of working in a regime of concurrency with the Competition and Markets Authority (CMA).[98]

Having regard more specifically to its competition mandate, its role encompasses not only detecting and sanctioning anti-competitive behaviour but also the application of the competition rules in a way that contributes to the "patients' interests (...) by improving the quality of these services (...) and reducing inequalities in respect of both access to service and outcome of treatment.[99] It has been suggested therefore that this aspect of Monitor's mandate allows it to authorise otherwise objectionable behaviour on the ground that the latter is regarded as justified and indispensable to secure "(…) seamless, well-coordinated and uninterrupted provision of health care services (…)" in accordance with clinical considerations:[100] they should be inspired by qualitative, clinically led considerations and should focus on striking an appropriate balance between the "costs" associated with a loss of competition (e.g. in terms of reduced incentives to innovate or to provide better "value-for-money" services for providers) and the benefits accruing to patients as a result of the practice, in light of hard evidence.[101] If the benefits, on the whole, overcome the drawbacks for rivalry and no less restrictive alternatives exist vis-à-vis the prima facie restrictive arrangement, the latter will be deemed to be "in the interest of patients".[102]

The 2012 Act has also had an impact on the procurement practices internal to the NHS, by imposing on commissioning bodies a general duty not to engage in conduct that is restrictive of competition. At the same time, however, it maintains a significant degree of discretion for commissioning bodies when they decide whether or not to "contract out" these services and, more broadly, which "tool" to adopt to select the "best provider": in this context, awarding the contract via an open bidding process is only one of the available options,[103] in parallel with, inter alia, entrusting the provision of the services to a "single capable provider" or supplying them "in house".[104] Furthermore, even when the commissioning body determined that "going out to tender"

[95] See e,g, Siverbo, cit. (fn, 92), pp. 415-416.
[96] See inter alia Timmins, cit. (fn. 74), pp. 4-5.
[97] Sanchez-Graells, cit. (fn. 85), p. 20.
[98] See Timmins, cit. (fn. 74), p. 3.
[99] Sanchez-Graells, cit. (fn. 85), p. 20; see Article 62(4), Health and Social Care (England and Wales) Act 2012.
[100] Ibid.
[101] Ibid.
[102] Timmins, cit. (fn. 74), p. 21; see also Monitor, Substantive Guidance on procurement, patient choice and competition regulations, (2013), available at: http://www.monitor-nhsft.gov.uk/s75, pp. 61 ff.; see especially pp. 62-63.
[103] See Monitor, Substantive Guidance, cit. (fn. 102), p.39.
[104] Id., p. 20; see also p. 41.

was the best option, it would remain entitled to rely on criteria not necessarily linked to the concept of "best value for money"[105] and based on non-monetary considerations, albeit within the constraints of predictability, transparency, non-arbitrariness and non-discrimination.[106] Paramount to the adoption of these decision must be a commitment on the part of the CCGs to "*ensuring [inter alia] quality, continuity, accessibility, affordability, availability and comprehensiveness of the services, the specific needs of different categories of users, including disadvantaged and vulnerable groups (…)".*[107]

Thus, Monitor has indicated that commissioning bodies can, for instance, subordinate cost reduction demands to the need to "co-locate" services by selecting providers acting in a certain area if this is regarded as objectively necessary to meet a clinical need;[108] they can also restrict the pool of potential bidders only to those providers whose services meet certain requirements of quality, on the basis of medical considerations or allow two or more successful bidders to cooperate in the provision of services provided that any loss in "short-term" competition is counterbalanced by actual or future gains in terms of patients' choice.[109]

It is suggested that this approach remains broadly consistent with, and can therefore be accommodated in the framework of principles governing EU public procurement: as was discussed in section 2.2, the "light touch regime" applicable to the award of public contracts concerning "essential services to the person" allows awarding bodies to rely on selection criteria that are not exclusively based on the "value for money" principle.[110] In any event, awarding bodies must not act in a way that can lead to the elimination of all competition in the bidding process, especially in respect of access to it.[111] As a result, commissioning bodies can, for instance, subordinate cost reduction demands to the need to "co-locate" services by selecting providers acting in a certain area if this is regarded as objectively necessary to meet a clinical need;[112] they can also restrict the pool of potential bidders only to those providers whose services meet certain requirements of quality, on the basis of medical considerations or allow two or more successful bidders to cooperate in the provision of services provided that any loss in "short-term" competition is counterbalanced by actual or future gains in terms of patients' choice.[113] However, these benefits must be "material" to the practice, likely to be realised within a relatively short time and supported by appropriate scientific research; in addition, commissioning bodies should consider whether a "less restrictive alternative" exists vis-à-vis the arrangement in question, in order to attain these outcomes.[114]

The above analysis suggests that the 2012 reforms have introduced a framework for the publicly funded provision of healthcare services inspired by "neoliberal", relatively market-driven principles. These tenets are, however, tempered in their application by a recognition of the sensitive nature of these economic activities: in this context, the role of the EU-inspired "light touch regime" in respect to procurement practices, on the one hand, and the notion of "patients' interest" are crucial for the purpose of allowing non-economic benefits in terms of greater quality, availability and accessibility of care to prevail over market-oriented considerations.[115] It is however just as evident that the 2012 reforms, by creating greater space for the involvement of private providers that often

[105] Id., pp. 38-39.
[106] Id., p. 20-21; see also p. 41-42.
[107] See Article 76(8), Directive of the Council and the European Parliament 2004/24/EU, [2014] OJ L94/65.
[108] Id., p. 26.
[109] Id., pp. 27-30; see also pp. 45 ff. For commentary, see e.g. Sanchez-Graells, cit. (fn. 85), pp. 28-29.
[110] See e.g. Monitor, Guidance, cit. (fn. 102), pp. 18-19; see also, mutatis mutandis, pp. 64-65.
[111] Ibid.
[112] Id., p. 26.
[113] Id., pp. 27-28; see also pp. 45 ff.
[114] Ibid.
[115] Ibid.; see also, mutatis mutandis, the approach adopted by the Commission in its Guidance on the application of Article 101(3) TFEU, [2004] OJ C101/97, e.g. at para. 32-33, para. 48, 51-54, 107-114. For analysis of issues arising from the impact of EU competition law on health services, see Odudu, "The impact of EU competition law on national healthcare systems", (2013) 38(4) ELRev 457.

act with a profit-making purpose, raises more general questions as to whether the Service can still maintain its "mutuality-based" nature.[116] It has been suggested that the question of whether these services are likely to remain of a solidarity-led, as opposed to profit-making, nature should be addressed by taking into account all the features characterising the manner in which they are provided.[117] Thus, rather than carrying out a "granular evaluation" of each agreement governing the delivery of these services,[118] regard should be had to a variety of factors, such as the ratio between the price charged to health authorities and the costs borne by the provider, of the manner in which these charges are determined and of how and by whom (i.e. whether these decisions are taken by the state authorities or are left to the parties' freedom to contract, for instance) the corresponding benefits for users of the services in issue are decided.[119] The assessment of the degree of control that the Government exercises on both the services themselves and the conduct of their providers is also essential.[120]

In light of the forgoing analysis, it is argued that while the 2012 reforms heralded numerous and very significant changes in the way in which state-funded health care is provided in England and Wales, by opening up this sector to greater private firms' involvement, they have not affected the "citizen-facing" aspects of these important public services. It is argued that to the extent that these services remain "free at the point of need", they retain, on the whole, their "solidarity based" nature, even when they are supplied via a non-state actor. Consequently, it is submitted that the rules on competition may not be applicable to the activities undertaken by the entities concerned.[121] Furthermore, having regard to the role and approach adopted by Monitor in these matters, the notion of 'patients' interest' is likely to prove an effective instrument to introduce considerations of "public policy" in the assessment of prima face anti-competitive conduct (such as, inter alia, cooperation arrangements), so as to achieve continuity of care and ensure more seamless service provision.[122]

In light of the forgoing analysis, it is concluded that the 2012 reforms have marked a move toward the extension of free market principles to the functioning of the NHS in England and Wales: consistently with the wide powers of appreciation that it enjoys in this area, the Parliament in Westminster has extended competition and patients' choice principles to certain aspects of this sector, without however altering the "patient-facing" nature of these services, which remain free at the point of need.

In this context, it is emphasised that the derogations in the public interest that the TFEU expressly allows via Article 56, taken together with the "safety valves" provided by the Health and Social Care Act 2012--such as the concept of "patients' interest"--are likely to ensure that, whenever this is regarded as necessary to safeguard high levels of public health and is kept within the limits of the principle of proportionality, non-economic criteria can be relied upon to justify restrictions to the application of market-oriented principles.

3.4. Beyond the single market: EU common commercial policy and possible implications for state-funded healthcare--access to all areas?

The previous sections discussed the position of taxpayer-funded healthcare services within the TFEU and highlighted that while these activities are subject in principle to the rules on free movement,

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[116] Case T-319/99, FENIN, cit. (fn. 16), para. 35-37. See also, mutatis mutandis, Bettercare v DGFT, [2003] ECC 40, especially, paras. 98-99 and 101-102. See also Sinclair, "Undertakings in competition law at the public-private interface—an unhealthy situation", (2014) 35(4) ECLR 167 at 168-169.

[117] Sauter, cit. (fn. 27), p. 465-466.

[118] Sinclair, cit. (fn. 116), p. 169.

[119] Sauter, cit. (fn. 27), p. 466.

[120] Id., pp. 464-465.

[121] See Monitor, Guidance, cit. (fn. 102), p. 62-63.

[122] Ibid.

their nature justifies the existence of derogations to the application of these Treaty rules. It was observed more generally that in accordance with broader EU tenets, such as the principles of conferral and of subsidiarity, the member states remain "sovereign" on their healthcare systems: as was confirmed by the EU Court of Justice, to the extent that they are best placed to assess the healthcare needs of their population, domestic authorities should be allowed a broad discretion in deciding how to design and regulate the provision of publicly funded health services, with the Union only empowered to enact measures aimed at "supporting and coordinating" this function, so that the internal market is not impaired in its operation.

However, as was briefly illustrated in section 3.1, the way in which the member states exercise these powers can have a significant impact on the scope of application of many single market principles: as was observed in sections 3.2 and 3.3 in relation to the NHS structure in, respectively, Scotland and England and Wales, the decision of "how much" or "how little market" to inject into the provision of taxpayer-funded medical care that reaches the patient "free at the point of need" remains solely with the domestic authorities. It is however undeniable that the forgoing analysis has only addressed questions concerning the interplay between member states' powers in this area and the internal powers enjoyed by the EU. It may be reminded that according to Article 207 TFEU, the Union enjoys the power to enter into agreements with third countries in matters of common commercial policy: as is well-known, as a result of the Treaty of Lisbon, this area of competence now encompasses also trade in services. Perhaps more importantly, it should be emphasised that this power belongs exclusively to the EU.[123] In light of the forgoing, it is not entirely surprising that the current negotiation of the EU/US Transatlantic Trade and Investment Partnership (TTIP) have raised questions as to the extent to which lowering the barriers to trade in EU markets for undertakings affiliated to the a country such as the US, where healthcare is almost entirely subject to the rules of the market, could encourage the process of privatisation of this sector also in the member states of the Union. The purpose of this section is to explore whether these concerns are justified.

The limited remit of this contribution does not allow for an examination of the issues arising from the scope and manner of exercise of the EU's treaty-making powers. However, it is indispensable to note that according to Article 207(6) TFEU the exclusive competence enjoyed by the Union in this area must not be exercised in a way that either alters the division of competences between the EU and the member states or results in "the harmonisation of legislative or regulatory provisions of the member states" in area where such harmonisation is not allowed. It may be added that the case law of the EU Court of Justice has gradually evolved from a relatively generous interpretation of the scope of the Union's external powers that had been motivated by a concern for the effective attainment of the Treaty objectives to a far more restrictive reading of the provisions governing treaty making authority.[124] Thus, the EU Court of Justice held that these powers could only be implied on the basis of the existence of a co-extensive internal competence if the unilateral stipulation of a treaty by individual member states could have endangered the integrity of the Union internal rules that largely covered the same area, in light of a careful examination of their “nature and content (…), current state and (…) future development.[125]

It is argued that these principles, which should be read also in light of the more general commitment to introducing greater clarity and certainty in the delimitation of member states/EU competences, undertaken at the Lisbon IGC, remain broadly consistent with the principle of

[123] See e.g. most recently case C-81/13, Commission v Council, Opinion of AG Kokott, 17 July 2014 nyr, para. 132-133. For commentary, see e.g. Kostandinides, “EU foreign policy under the doctrine of implied powers”, (2014) 39(4) ELRev 511, p. 524.

[124] See chiefly case 22/70, Re: ERTA, [1971] ECR 263, para. 13; see also para. 18-22. See also Opinion 1/76, Re: Inland Waterway Vessels Convention, [1977] ECR 741; Opinion 1/94, [1994] ECR I-5267, especially para. 77, 85-86. For commentary, see Emiliou, "Toward a clearer demarcation line?", (1994) 19(1) ELRev 76 at 82-83; also Hartley, The Foundations of European Union Law, 8th Ed., 2014: OUP, pp. 180-181.

[125] See Opinion 1/2003, Re: Lugano Convention, [2006] ECR I-1145, para. 126-127; for commentary, see inter alia Cremona, “Extending the reach of the AERT principle”, (2009) 34(5) ELRev 754 at 762-763.

conferral.[126] Accordingly, it is submitted that whether TTIP may have an impact on the provision of publicly funded healthcare services is a question that can only be addressed upon an assessment of the competence that the Union and the member states respectively enjoy in this area.[127] On this point, two considerations should be made: the first concerns the nature of the powers that the Union enjoys in the field of common commercial policy. It is observed that while this is an area of exclusive competence to the Union, its exercise must, according to Article 207 TFEU, conform not only to the "principles and objectives of the Union's external action", but also to more general principles affecting the exercise of the competences that the member states have conferred to the EU in the founding Treaties.[128] The circumstance that, according to the last indent of that provision, the Union cannot, as was anticipated above, either alter the scope of its own powers or bring about harmonisation in areas in which this type of action is not allowed, can be read as confirming that the scope of the powers of external action enjoyed by the EU is necessarily constrained by the principle of conferral:[129] thus, it is submitted that to the extent that the Union cannot adopt internal harmonisation measures concerning the provision of publicly funded health care services, it also lacks the power to achieve the same objective by way of undertaking international obligations, as part of its common commercial policy remit.[130]

From the forgoing flows the second consideration, namely that especially when trade negotiations aim to secure commitments In a wide range of areas, as in the case of TTIP, regard should be had to what type of competence the EU enjoys in respect to each aspect of the envisaged agreement.[131] It is argued that if these areas are subject to shared powers between the Union and the member states, the final outcome of the negotiations is going to be a “mixed” agreement: as a result, for those obligations affecting fields in respect of which national authorities retain powers of action, the final agreement will have to be ratified by each member states in accordance with the relevant constitutional requirements.[132] In addition, in the course of the negotiations, member states must be "closely associated" with the Commission so that their interests can be appropriately taken into account.[133]

It should be emphasised that this approach has been expressly endorsed by the EU Commission: in a letter sent to the "presidents and chairmen" of the parliaments of the member states, the Commissioner for Trade stated that the continuing association of the member states in the negotiation process, taken together with their power to scrutinise the final outcome, would contribute to assuaging the concerns for protecting the margin of appreciation that the domestic authorities enjoy in areas of joint competence.[134] It is submitted that the negotiation of TTIP, whose remit could potentially encompass the trade of health services, some of which may be taxpayer-funded in individual member states, represents a very good example of how a prima facie wide and exclusive authority to act such as the one enjoyed by the EU in common commercial policy matters must be necessarily limited by the corresponding and extensive sovereignty that Article 168 TFEU

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[126] See e.g. Opinion No 1/2003, Re: Lugano Convention, [2006] ECR I-1145, para. 126-128, 132-133; see also case C-81/13, cit. (fn. 123), judgment of the ECJ, 18 December 2014, para. 61-62. For commentary, see e.g. Kostantinides, cit. (fn. 123), p. 512-513; also, mutatis mutandis, Cremona, “Balancing Union and member states interests”, (2010) 35(5) ELRev 678 at 692.

[127] See e.g. Opinion 1/2008, Re: GATS, [2009] ECR I-11129, para. 119-120; see also para. 132-134.

[128] See e.g. caseC-81/13, Commission v Council, Opinion of AG Kokott, 17 July 2014 nyr, para. 58, 70, 77-81.

[129] Id., para. 74-81; see also judgment of the Court, 18 December 2014, nyr, para. 62.

[130] See inter alia mutatis mutandis, Opinion 1/2008, cit. (fn. 109), para. 120; see also para. 133-134.

[131] Id., para. 132-133.

[132] Ibid.; see also Report to the House of Commons, “The Transatlantic Trade and Investment Partnership”, 18 December 2014, available at: www.**parliament**.uk/briefing-papers/sn06688.pdf, pp. 15-16.

[133] See e.g. Opinion 1/2008, cit. (fn. 127), para. 134-136; see also Report to the House of Commons, cit. (fn. 132), p. 16; for commentary see e.g. McKee et al, "Public Health policies", in Hervey et al. (eds.), cit. (fn. 20), pp. 231-281, especially pp. 235 ff.

[134] C(2014) 7557 final, available at: http://ec.europa.eu/transparency/regdoc/rep/3/2014/EN/3-2014-7557-EN-F1-1.Pdf, especially p. 2; see also Report to the House of Commons, cit. (fn. 132), p. 3.

recognises as belonging to the Member States.[135] As was illustrated earlier, health care provision is a field in which the EU only enjoys "coordinating" and "supporting" competence, that is, the power only to ensure that the "sovereignty" maintained by the member states over publicly funded health care provision does not distort the functioning of the internal market, with the Member States remaining competent to pursue public interest goals[136] through organisational, financial and regulatory measures---albeit conforming to the principles of "necessity" and "proportionality".[137]

It is acknowledged that the Union enjoys a certain power to regulate the "single market aspects" of the publicly funded provision of these services to the benefit of the citizens of the Union and has indeed exercise it, e.g. by enacting the Patients' Directive.[138] Nonetheless, it is strongly doubted that a corresponding external competence to act could be advocated solely on the basis of this limited authority to take action.[139] It is reminded that, as was expressly stated by the EU Court of Justice in a recent judgment, the undertaking of international obligations can only be allowed as the expression of an implied external power if the corresponding internal competence--in this case the power to "support and coordinate" member states' internal health care policies so as to safeguard the good functioning of the internal market---cannot be exercised affectively.[140] As was explained by AG Kokott in a recent Opinion, if the effective application of common internal rules was not adversely affected by the absence of external rules, designed, e.g., to deal with issues arising from the legal position of third country nationals, the Union could not legitimately claim an unexpressed power to enter into international obligations in areas of joint competence with the member states.[141]

Against this background, it is argued that the Union could not, by means of TTIP, undertake obligations that may de facto result in the "privatisation by stealth" of the member states' frameworks (both organisational and normative) for the provision of publicly funded healthcare services. It is submitted that to hold otherwise would amount to allowing the Union to short-circuit the system of principles designed to govern the scope of its powers vis-a-vis those enjoyed by the member states and in particular to act in disregard of the "sovereignty" that the latter retain over their healthcare systems.[142] It is further submitted that even if the Union was committed to negotiate with a third country a greater degree of liberalisation of the trade in services and therefore to accept that undertakings affiliated to that state should enjoy greater market access within the EU, the member states would still be able to rely on their "sovereignty" over taxpayer funded medical care to regiment access to their own market for these services.[143] Consequently, it is argued that only if the member states agreed to amend the Treaty so as to confer on the Union stronger and more extensive powers in this area could the EU seek to engender greater convergence in matter of healthcare provision--including provision that is publicly funded--perhaps by seeking to introduce more "market led" modes for the supply of these services.[144]

It is emphasised that the EU Commission itself seems to have adopted a position which is in all consistent with the forgoing approach. In a letter dated 8 July 2014 and addressed to the Chair of the All-Party Parliamentary Group on TTIP, the Director for the USA and Canada division of the EU Commission's Directorate General for Trade expressed the view that adhering to TTIP would not affect the "rights of the Member States to manage their own health systems according to their

[135] See also, e.g., Opinion 1/2003, cit. (fn. 127), para. 126-128; see also para. 133.
[136] See inter alia, Geraets-Smits et al., cit. (fn. 23) para. 44-45; also Watts, cit. (fn. 22), para. 86.
[137] See e.g. , mutatis mutandis, Kohll, cit. (fn. 5), para. 18.
[138] Directive of the European Parliament and the Council of 9 March 2011 No 24, cit. (fn. 24).
[139]See inter alia Opinion 1/03, cit. (fn. 127), para. 126-127; see also case C-81/13, cit. (fn. 123), para. 57-59; see also AG Opinion, para. 102-104 and 106-107.
[140] See e.g. Opinion 1/2003, cit. (fn. 127), para. 126-127; see also case C-81/13, cit. (fn. 123),para. 57-59.
[141] Case C-81/13, cit. (fn. 123), Opinion of AG Kokott, para. 106-107; see also para. 111-112 and 120-122.
[142] See e.g. mutatis mutandis, Kohll, cit. (fn. 5), para. 18.
[143] See e.g. ibid.; see also Geraets Smits, cit. (fn. 23), para. 44-45.
[144] See inter alia, mutatis mutandis, case C-81/13, cit. (fn. 123), judgment of the Court, para. 44-46, 52-55.

various needs".[145] Accordingly, the Commission confirmed that any commitment to increasing market access in this field would neither affect national discretion to decide how to provide these service nor change existing approaches to public procurement, which would remain amenable to the "light touch approach" discussed above.[146] It is added that this conclusion seems to be confirmed by the recently stipulated Canada/Europe Trade Agreement (CETA), where the negotiating parties undertook to refrain from applying market access, liberalisation and non-discrimination principles in the field of health care and of other similar, "sensitive services".[147]

It is concluded that the ongoing trade negotiations between the EU and the US represent both a challenge and an opportunity for either party: an opportunity, because they are likely to create greater trade and growth opportunities; and a challenge, because they raise complex questions as to how "local realities", that are typical of "sensitive sectors", such as healthcare, are going to continue being addressed at "local level", even though this may entail a derogation from general principles of market access. It is however clear from the forgoing analysis that the careful observance of the rules governing the observance of the rules governing the competence of the EU vis-a-vis the powers enjoyed by the member states is going to be crucial to ensure that legitimate inroads in the free movement, competition and market access principles are maintained, so that the good functioning of the EU single market, also in the wider context of an increasingly globalised world trade, does not unduly impair the attainment of legitimate public interest goals.

4. Publicly funded health care between local needs and open markets: "special services" in an increasingly globalised economy? Tentative conclusions

Providing healthcare services free at the point of need has been a hallmark of modern welfare states since their very inception: however, a growing and increasingly ageing population has placed the framework for the delivery of these services under significant pressure, thus prompting important questions as to the sustainability of their current mode of provision. In this context, the role of private undertakings, acting on a commercial basis both alongside and instead of public agencies has emerged as a feature in many member states. At the same time, it has prompted pressing questions as to what extent it may be compatible with the mutuality-based nature of these services, typical of the tradition of many member states, including the United Kingdom. In this context, the impact of European integration and the realisation of the single market has been significant and has sometimes added to the perception that due to the influence of the free movement, competition and public procurement rules existing within the EU legal system safeguarding the solidarity rationale characterising these services may become more and more difficult.

A push toward increasingly integrated global markets beyond the EU, via the Union's proactive stance in the field of international trade, has contributed to these concerns. This paper has analysed a number of issues arising from the interplay between the realisation of the internal market within the EU and the discretionary powers of the member states as regards the regulation of the provision of publicly funded healthcare services. It was argued that while in principle these constitute "services" within the meaning of the TFEU and are consequently subject to the free movement rules, the concern that, as a result of the application of these and of other "market-oriented" principles, they may be heading toward a "privatization by stealth" are more apparent than real.

The forgoing analysis touched upon the nature and scope of the competences that the EU and the member states enjoy in this field: it was shown that while these services, even when they are

[145] See the letter sent to John Healey MP (Chair, All Party Parliamentary Group on TTIP) by Ignacio Garcia-Bercero, DG Trade, EU Commission, on 8 July 2014, available at: http://trade.ec.europa.eu/doclib/docs/2014/july/tradoc_152665.pdf.

[146] Ibid.; see also, e.g., mutatis mutandis, case C-160/08, Commission v Germany, judgment of 29 April 2010, para. 124-126.

[147] See CETA—summary of the final negotiations, available at: http://trade.ec.europa.eu/doclib/docs/2014/december/tradoc_152982.pdf, pp. 10-11.

publicly funded, remain subject to the single market rules, Member States enjoy significant discretion for constructing legal justifications at the basis of limits to the reach of the free movement requirements in this area. The EU, on its part, only enjoys a narrow power in this field, which is limited to "supporting and coordinating" the Member States' action so that the exercise of their "sovereignty" over healthcare systems does not hamper the good functioning of the internal market. A similarly subsidiarity-based approach seems also to underscore the way in which the award of public contracts can occur for healthcare services: it may be suggested that the light touch regime affecting the award of such contracts would allow the awarding bodies to apply criteria for the selection of winning bids that are based on, inter alia, “geographic proximity” of providers to users of services or generally on non-economic considerations.

The provision of publicly funded medical services in the United Kingdom has offered a clear example of how individual member states can exercise their powers in this area and thereby shape the reach of the competition rules, of principles of market access and free movement of services for the purpose of protecting the mutual nature of taxpayer-funded healthcare from the “vagaries of the market forces”. It was acknowledged that the 2012 reforms in England and Wales have been very controversial and have resulted in significant differences vis-à-vis the functioning of the NHS in Scotland. However, it was argued that the Westminster and Holyrood parliaments remain “sovereign” over decisions in this area, in accordance with Article 168 TFEU and can therefore determine "how much" or "how little market" they may regard as appropriate in this sector, by relying both on their freedoms to choose how to design these frameworks and on the “safety valves” that EU and domestic law provide for this purpose.

Toward the end, this paper briefly addressed the concerns that had been raised in this area in connection with the negotiation of the EU/US Transatlantic Trade and Investment Partnership: it was argued that just as with the adoption of internal measures, the action of the Union on the international plain remains subject to the general principle of conferral: consequently, it was suggested that short of amending Article 168 TFEU to widen its powers in this field, the EU would not be empowered to act in a way that de facto alters the boundaries of its powers and thereby seek to engender convergence among the varying approaches adopted by each member state in regulating the functioning of and the access to taxpayer-funded healthcare around more market-based principles.

In light of the forgoing, it may be concluded that while continuing to provide state funded medical services "free at the point of need" remains a challenge for all member states and must be pursued in accordance with the broader principles and goals enshrined in the TFEU, the Treaty itself safeguards the domestic powers of appreciation in this area, through the general principles of conferral, subsidiarity and proportionality. Consequently, while it is acknowledged that the presence of private providers in this sector may become more commonplace in the future, it will be entirely incumbent on the member states to decide whether and in what measure to "open up" taxpayer-funded healthcare to competition. The EU, on its part, is only empowered to enact measures designed to avoid that state measures do not unduly impair the functioning of the internal market: however, it cannot, unless the Treaty was amended to this effect, hasten or more generally influence the direction of travel or the speed of this clearly national process.